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ABSTRACT

According to a June 1989 report by the Council of Chief State School Officers, 41 states have adopted model human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention programs and curricula for use in local school districts. Effective HIV/AIDS education takes a comprehensive approach that includes teacher training, community involvement, program evaluation, and ongoing policy review. Ongoing training assistance usually is the responsibility of a curriculum administrator. School policies and education programs should reflect the change in terminology that applies to HIV/AIDS education. For instance, HIV has replaced AIDS as the term of choice because it covers the full range of illness, from asymptomatic infection with the virus (HIV) to the onset of clinical disease (AIDS). State education departments and the Centers for Disease Control will be conducting surveys of a sample of school districts to measure a comprehensive set of priority health risk behaviors among students, including behaviors that can result in transmission of HIV. (MLF)

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YES. Vast numbers of school boards have heeded the calls from legislatures, state boards of education, and public health officials to educate students and school communities on the risks of HIV (human immunodeficiency virus) transmission. According to a June 1989 report by the Council of Chief State School Officers, 41 states have adopted model HIV prevention programs and curricula for use in local school districts, with two-thirds of those states offering some funding as well.

BUT . . . it's not time to close the policy manual on curriculum (health education), students (contagious/infectious diseases), and personnel (staff health and safety). More work needs to be done. Where curricula and programs are in place, their effectiveness should be fortified with teacher training, ongoing commitment to keeping information up to date, community involvement in the development of broad-based HIV prevention efforts, and program evaluation. Where HIV education is not yet being provided, it's time to get started.

Brenda Z. Greene is manager of NSBA's AIDS education project, which is supported by a cooperative agreement with the Centers for Disease Control.

Make education a priority

Although the rate of HIV transmission seems to be slowing among homosexual (gay) men, the incidence of infection among young people is increasing (40 percent in the last two years), despite the fact that absolute numbers remain small — 447 reported cases (through November 1989) among youth ages 13 to 19. According to an article in *The New York Times* (October 8, 1989):

> Not only are teenagers becoming infected with the virus, but it is also being transmitted through heterosexual intercourse, and equal numbers of males and females are infected. By contrast, among adults the virus has been transmitted primarily through homosexual sex or intravenous drug use, and the number of infected men far exceeds the number of infected women.

The number of teenagers infected with the AIDS virus, HIV, is not known, but conditions are ripe for its spread: many teens have multiple sex partners and few use condoms. At particular risk are runaway or "throwaway" youth, who often earn money through prostitution.

Effective HIV/AIDS education takes a comprehensive approach, putting its mark not only on policy and curriculum but on teacher training, community involvement, program evaluation, and ongoing policy review. Sound policy development, undoubtedly, is the first stroke. But without a commitment to planned implementation and ongoing feedback, HIV/AIDS education will resemble an unfinished portrait.

Teacher training is a must

Although approaches to HIV/AIDS education are diverse (e.g., as a part of comprehensive health education, as a component of a family life or human sexuality course, or as a stand-alone unit), the most critical factor is a constant — teacher training. Teachers not only have to be well versed in the facts about HIV and the curriculum content, but also must be prepared with strategies to address students' attitudes, beliefs, and skills — if behavior is to be influenced.

We all know what's good for us — wearing a seatbelt, flossing our teeth, exercising regularly — but it isn't until we believe that doing these things is going to benefit ME that we make the effort to learn how to do it and change our behavior. For teenagers, who have a sense of invulnerability and immortality, the challenge is even greater.

School board decisions, particularly about budget resources, influence how well teachers are prepared to do their jobs. Inservice training can be expensive, for example. It requires paying

continued on page 2

Inside Updating. . .

Trends ..... ***p. 4***
Commercialism in schools
Policy Adviser ..... ***p. 8***
Communicating with special needs parents

EA 021 523

Aids education from page 1

substitute teachers to cover classes for teacher training or paying teachers for extra hours. It requires having a specialist on staff or hired as a consultant to develop and implement the training program.

Less expensive alternatives exist, however. Technology offers options ranging from videotapes on instructional methods to teleconferencing via satellite dish. Along with education about HIV provided by medical experts (e.g., local health department, medical society), videotapes offering teaching tips or classroom instructional material can be viewed at the convenience of teachers — at school or at home.

Teacher self-education facilitated by quality written materials also is a possibility, although interactive formats are more effective. Try to include directed responses in the materials package. To respond to likely questions and discussion topics, require follow-up contacts by a trained staff member or small peer group exchanges.

Also of benefit is a three-ring binder on HIV/AIDS education designed to provide easy access to a year's worth of training resources. Your state education agency, other districts, health agencies, and community-based organizations are some sources of information and assistance in developing a resource file. Another idea is an in-house HIV/AIDS education newsletter that adapts general advice and tips to the special needs of schools.

Ongoing training assistance usually is the responsibility of a curriculum administrator. Even if the district does not have a full-time HIV/AIDS education coordinator, the staff member assigned this responsibility should be known to teachers. Publicize the person's name, phone number, and position regularly to all teachers. In fact, consider designating a few hours of the administrator's week as a "hotline" or call-in time to encourage teacher feedback. If the district communicates on an electronic mail system, this vehicle also is a potential HIV/AIDS education vehicle. But ensure that teachers have convenient access to a computer terminal!

The administrator's responsibilities should include specialized attention to training school staff who have "caretaking" duties, such as coaches, counselors, and activity advisers. Anyone who interacts with students should be prepared to reinforce what is taught in the classroom about HIV prevention.

And don't forget to support regular training for the administrator in charge of HIV/AIDS education. "Train the trainer" programs are crucial in areas of knowledge that are expanding rapidly, such as HIV. For information on training opportunities, consult your state education agency (every state has an HIV/AIDS education coordinator), your state school boards association, or your local chapter of the American Red Cross.

Old news is bad news

The media adage of "old news is no news" applies to HIV/AIDS education. For instance, HIV has replaced AIDS as the term of choice because it covers the full range of illness, from asymptomatic infection with the virus (HIV) to the onset of clinical disease (AIDS). School policies and education programs should reflect this change. Also, successful administration of the drug AZT and other clinical treatments seem to be changing the prognosis for HIV infection from fatal to possibly chronic. This knowledge is important to convey — especially to underscore that prevention of infection is still the only sure way to avoid disease.

National and state sources of information on HIV and HIV/AIDS education — the Centers for Disease Control, the HIV/AIDS Coordinators at your state education and health agencies, NSBA, National Association of State Boards of Education, Council of Chief State School Officers, The National PTA, American Red Cross, state school boards associations, to name a few — supply ongoing and up-to-date information. But the sources must be tapped and used by school boards, administrators, and teachers before this knowledge will filter down to the classroom.

There is an apparent lessening of interest in HIV-related issues among school officials and educators. The feeling that we've already done it, i.e., adopted policies, implemented an instructional program, trained staff in infection control procedures, is pervasive. But there is an ongoing need to enhance efforts — to improve on what has already been accomplished.

For example, in September 1989, the National Association of State Boards of Education (NASBE) published *Someone at School has AIDS*, guidelines on policy issues concerning students and employees who are infected with HIV that were developed in collaboration with more than a dozen national education, law, and medical organizations including NSBA and the Centers for Disease Control. These guidelines are based on the most current research about HIV. If your school board has not already done so, review your existing policies in light of the new information; if your board hasn't already adopted policies on students and employees with HIV infection, now is the time to do so.

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Community involvement

HIV/AIDS involves the community in more ways than curriculum. When a student or teacher with HIV infection returns to the classroom, members of the school community either rally in support or oppose the action on health and safety grounds. Community involvement in policy development and review of instruction can be a double-edged sword, both sides to the good.

Although the rights of students and staff are largely governed by state and federal law, the acceptance of these individuals is not. Broad-based community involvement in developing an HIV/AIDS program can lead to widespread support for personnel and student policies because vital information on the nature of the virus and on how it is — and is not — transmitted is communicated to the public.

Establishing a standing advisory committee on health or HIV/AIDS education — composed of medical authorities, parents, school employees, and community members — is a wise move for many school boards. The committee can work through the many difficult areas of policy development, including curriculum explicitness, grade-level subject matter, and the community's approach to the "abstinence but otherwise..." dilemma. Committee members can become your district's key communicators — educating the public as they become more educated about HIV and instructional issues.

Evaluate, evaluate, evaluate

Whether it is your policies on HIV-infected students and employees, your instructional program for students, your training program for teachers, or some other HIV-related program, implementation is not the last step. Evaluation of what you are doing is critical.

For example, do teachers feel prepared to teach following the training provided? Is there additional or different assistance that should be provided?

Have your procedures for managing HIV-infected employees or students been implemented as planned? What obstacles arose, and how can they be overcome? Are your policies based on information that is consistent with what is taught in the classroom?

Are building custodians using proper infection control procedures to clean up blood spills? If not, how can training be improved? If no one knows, what monitoring procedures should be established?

Are students learning what they should know and are their beliefs, attitudes, and behaviors being influenced? Does the curriculum need revision to address gaps in the education program?

These are but a few of the questions that can be incorporated into the evaluation of your HIV education programs. Clearly, as with all district education programs and policies, evaluation and revision are important to their continuing improvement. ■

Do your students take risks with their health?

State education departments nationwide conduct annual school-based surveys to measure a comprehensive set of priority health risk behaviors among students, including behaviors that can result in transmission of HIV. The Centers for Disease Control also conducts a national school-based survey among a representative sample of high school students using a similar questionnaire. These surveys provide important information for planning state and local programs to prevent the spread of HIV among youth and other preventable diseases and conditions.

In 1990 the questionnaire will cover six categories of risk behaviors: behaviors that result in intentional or unintentional injuries; drug/alcohol use and tobacco use; sexual behaviors that result in HIV infection; other sexually transmitted disease and unintended pregnancies; dietary behaviors; and physical activity. Over time, it will be possible to assess whether various risk behaviors are increasing, decreasing, or remaining the same.

The information gained from these surveys can assist in the design of national and state efforts to reduce risk behaviors. They also can help local school districts assess the success of their health education programs toward reducing risky behaviors among youth. But clearance to conduct these surveys must be obtained at the local — district and school — level.

Your district may be invited to participate in one of these surveys. (You can't volunteer because the districts and schools selected are part of a scientifically designed sample and volunteer participants would damage the credibility of the data. Similarly, if districts and schools turn down the invitation, the results will be damaged to some extent.)

If your district is selected to participate, your policy on "Relations with Education Research Agencies" should guide your decisionmaking. It should state who has the responsibility for making decisions on the conduct of research surveys by outside agencies and, in general terms, for what purpose surveys can be conducted. Generally, research by outside agencies is encouraged when the results will benefit the district's education program and public education in general. These student behavior surveys can provide useful information for improving your health education and counseling services programs.